

Greg W. Sutherland, D.D.S., M.S. & P.S.

Orthodontic Specialist

www.smilesbysutherland.com

ID# _____

210 – 4th Ave SW

Puyallup, WA 98371

Phn: 253-848-4537

Fax: 253-841-0792

A B C

About your child

Today's date _____

Name _____
Last First MI

Nickname _____

Child's Home # _____/_____/_____

Child's Home Address _____

City State Zip

Name and phone # of dentist _____

Date of last visit to the dentist _____

Birthdate ____/____/____ Age: _____ M /F

School _____ Grade _____

Child Lives with _____

Hobbies/Sports _____

Names of Siblings & ages _____

How were you referred to our office? _____

About the parents

Marital status of parents: Married Separated Divorced Widowed Single

Mom's name _____

Parent Guardian Stepmother

Birthdate ____/____/____ SS# _____

Home # _____ wk# _____

Cell # _____ E-mail _____

Employer _____

Occupation _____

How long at this job? _____

Father's name _____

Parent Guardian Stepfather

Birthdate ____/____/____ SS# _____

Home # _____ wk# _____

Cell# _____ E-mail _____

Employer _____

Occupation _____

How long at this job? _____

Person Responsible for the account (if different from parent information above)

Name _____
First MI Last

Relationship to patient _____

Billing Address _____
Street City State Zip

Home # _____ Wk# _____ Cell # _____ E-mail _____

I understand that where appropriate, credit bureau reports may be obtained. I give permission for Dr. Sutherland's office to examine my child.

Signature _____

(Parent or legal guardian's signature)

PLEASE COMPLETE BOTH SIDES

Describe your child's current physical health: Good Fair Poor

Has your child ever had any of the following medical conditions? (check all that apply & explain below)

- Abnormal Bleeding
- ADD or ADHD
- Cancer
- Bone Disorders
- Pneumonia
- Sinus Problems
- Anemia
- Autism
- Epilepsy
- Heart Trouble
- Liver Involvement
- Speech Disorders
- Asthma
- Hyperactivity
- Developmental Delay
- Fainting Dizziness
- Diabetes

Has your child ever tested positive for Acquired Immune Deficiency Syndrome? Yes No

Please explain each item checked above: _____

Does your child have any of the following habits?

- Grinding/clenching teeth..... Yes No While asleep..... While awake
- Mouth breather..... Yes No..... While asleep..... While awake
- Nail biting..... Yes No Lip Sucking or biting..... Yes No
- Thumb or finger sucking..... Yes No Tongue thrust..... Yes No

Medical / Dental History

- Yes No.....Has your child had an orthodontic evaluation or treatment before?
If so, when and where? _____
- Yes No.....Was orthodontic treatment recommended?
If you could change anything about your child's smile or bite, what would it be? _____
- Yes No.....Have any other members of the family had orthodontic treatment? Who? _____
- Yes No.....Have there been any injuries to the face, mouth, teeth or chin? _____
- Yes No.....Has your child been informed of any missing or extra permanent teeth? _____
- Yes No.....Has your child ever had any pain/tenderness in his/her jaw joints?
- Yes No.....Does your child brush his/her teeth daily?
- Yes No.....Does your child floss his/her teeth daily?
- Yes No.....Is there any dental work that needs to be completed? _____
- Yes No.....Is your child currently under the care of a physician? Name of physician _____
Date of last visit _____
- Yes No.....Does your child suffer frequent colds or sore throats?
- Yes No.....Have your child's adenoids or tonsils been removed?
- Yes No.....Is your child currently taking prescription or over the counter medication?
Please list medication and reason it is being taken: _____
Please list any medications or things your child is allergic to: _____

Do you have any friends or relatives who are past or present patients of Dr. Sutherland? _____

What are the main concerns that you would like orthodontics to accomplish? _____

In case of emergency

Name of nearest relative not living with you _____ Relationship _____

Phone # () _____ Wk# () _____